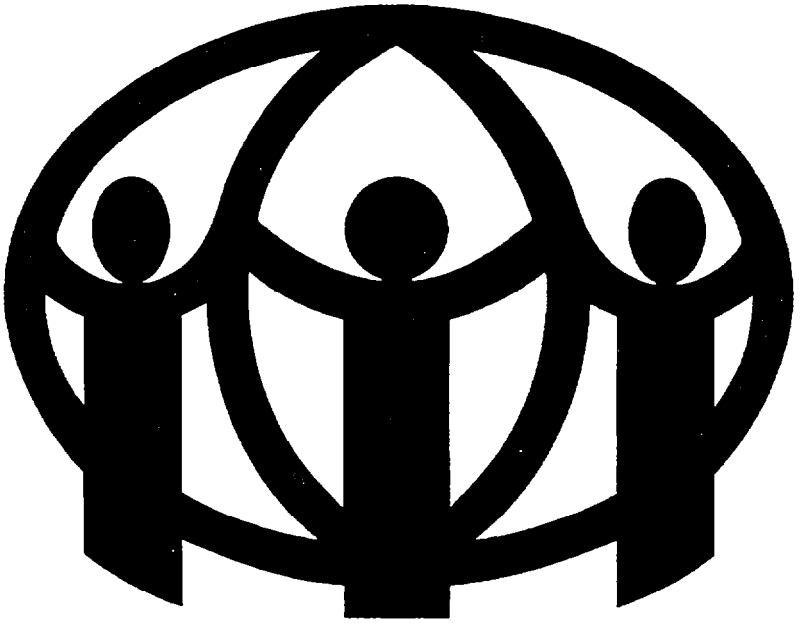
MID-TERM EVALUATION

for

CHILD SURVIVAL VIII PROJECT

FAO-0500-A-00-2065-00

HONDURAS



Submitted to:

United States Agency for International Development
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by:
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GLOSSARY

(Abbreviations and Spanish Terms)

ADRA ..... Adventist Development and Relief Agency
A.I.D. ..... (US) Agency for International Development (USAID local agency)
ARI ..... Acute Respiratory Infection
CentrodePesaje ..... WeighingSite
CHV ..... Community Health Volunteer
CESAMO ..... *Centro de Salud con Medico Odontologo* (Community Health Center with Dental Doctor)
CESAR ..... *Centro de Salud Rural* (Rural Community Health Center without Medical doctor)
CDD ..... Control of Diarrheal Disease
CS ..... Child Survival (Project/Program)
DIP ..... Detailed Implementation Plan
EMMA ..... *Empresas Materiales* (Small Enterprises)
EPI ..... Expanded Program of Itnmunization
FHIS ..... *Fondo Hondurenio de Inversion Social* (Honduranean Social Investment funds)
FIO ..... *Fundacion International de Ojos* (International Eye Foundation)
IMR ..... Infant Mortality Rate
KAP ..... Knowledge-Attitude-Practice
Litrosol ..... OralRehydrationSolution
MIS ..... Management Information System
MOH ..... Ministry of Health
MSPH ..... *Ministerio Salud Public0 de Honduras* (Public Health Ministry>
MTE ..... Mid-term Evaluation
OPD ..... *Organisacion Privado de Desarrollo* (Private Voluntary Organization, PVO)
ORS ..... Oral Rehydration Solution
ORT ..... Oral Rehydration Therapy
PAMI ..... *Program0 do Alimentacion Materno Infantile* (Feeding Programs for mothers and small children)
PHC ..... Primary Health Care
Proyecto Sobrevivencia Infantile ..... Child Survival Project
SDA ..... Seventh-day Adventists
SED ..... Small Enterprise Development
UROC ..... *Unidad de Rehidracion Oral Communitaria* (Community Oral Rchydration Station)
us AID ..... United States Agency for International Development
Voluntatio de Salud de la Communidad ..... Community Health Volunteer

INTRODUCTION

The scope of work, as assigned to the evaluation team by USAID and ADRA International, was three-fold in its nature:

First, to provide the project staff with an external perspective on the progress of the program for the last 20 months (starting from October 1, 1992), and the potential of the project for reaching the stated objectives by the end of the funding period (which is September 30, 1995).

Second, to assess whether the project is being carried out in a competent manner, and the priorities for action are clearly identified. In this regard the team was asked to review management and supervisory practices, identity needs for refresher training, examine the extent of community participation in the design and implementation of the project, and evaluate the adequacy of the technical backstopping by ADRA International.

Third, the evaluation team was asked to help ADRA Honduras to review the relevant lessons learned, and to identify new strategies or methodologies that are potentially applicable to other health and child survival projects.

The evaluation team approached this exercise with the assumption that the project staff has conducted all their activities to the best of their abilities. The team worked closely with the staff and examined all the project systems and progress to date in order to determine what has worked and what has not worked. The focus was on lessons learned and planning for the future. The mid-term evaluation report will address issues related in managing the project to its conclusion.

The mid-term evaluation team was composed of Rudolf Maier, consultant and team leader, Andrews University, Berrien Springs, Michigan, USA; Dr. Gerard Latchman, Technical Assistant, Department of Evaluation, ADRA International, Washington, D.C., USA; Lit. Nelson Tabares, ADRA Honduras, Child Survival Project Director, Tegucigalpa, Honduras; Dr. (Mrs.) Aura Delia Ordonez de Castillo, MD, Health Coordinator, ADRA Honduras Child Survival Program.

The team reviewed the evaluation scope of work (purpose and goals) and USAID guidelines (May 29) for the Mid-term Evaluation. The team interviewed the six community project supervisors (May 30) and Community Health Volunteers as well as clinic (CESAMO) directors and social workers (May 30, 3 1, June 1). The team also visited the community health centers (CESAMOs), family gardens and income generating projects in San Francisco Colony (May 3 1) and Flor de1 Campo (June 1). Two newly established UROC units were visited (May 3 1 and June 1). Separate visits to MOH's NGO Coordinator ***(Coordinator de Organizaciones Privados de Disarrollo--OPD)*** took place on June 2. The local A.I.D. officer in Tegucigalpa was briefed June 3. June l-5 was spent in briefing sessions, team discussions and report writing in the CS office in Tegucigalpa. The final report was presented to ADRA CS staff and the ADRA director as well as the ADRA board chair on June 6.

The result of the group effort has been summarized in Attachment 4, as ***Observations and Recommendations.*** That document has been presented as a joint statement to the ADRA Honduras and ADRA International staff Additional data has been collected with the assistance of the ADRA Honduras staff Those findings are now presented as ***An Analysis of the Adventist Development and Relief Agency's Child Survival Project Located in the San Francisco and Flor del Campo Colonies of Tegucigalpa, Honduras.***

The discussions and interviews of the evaluation team, as well as the material provided by the ADRA Honduras staff contributed to this document. This document has not been presented to the whole team nor to ADRA Honduras for its "approval." In this way I take the responsibility for the content of this report.

Rudolf Maier
Andrews University
Berrien Springs, Michigan

June 15, 1994

EVALUATION REPORT

1. Accomplishments

How many months has the project been operating? What are the measurable inputs (ag. training sessions held), outputs (e.g. persons trained, mothers educated), and outcomes (e.g. immunization coverage, change in mothers' use of ORT)? Todate, how many infants, children under five, and mothers have been reached by CS interventions under this project? What proportion is this of the total potential beneficiary population of infants, children under five, and women of child-bearing age?

a. Time Frame

The contract for this project was signed on October 1, 1992 by ADRA International. The Honduras CS project director was hired January 1, 1993. Field supervisors were hired in February 1993. Other project personnel was hired in March 1993. Field activities started in July 1993. The project has been in operation for 19 months. The actual field operations have been ongoing for 10 months. The start-up time for the Honduras CS office took 3 months, which is reasonable because ADRA Honduras had no prior experience in CS activities. (ADRA Honduras has operated a USAID funded Matching Grant Project in a rural setting in the 1980s).

b. Inputs

The following inputs contributed to the present status of the CS program:

(1) ***Training-***

(a) ADRA International conduced a training workshop in Honduras February 1993 to orient office staff in CS requirements and baseline survey work.

(b) ADRA Honduras and CESAMO staff training of field supervisors in March/April 1993.

(c) ADRA Honduras selected and trained community health volunteers in May and June 1993.

(See Appendix 1 and 2 for complete training schedule, trainers and participants).

(2) ***Training Manuals-***

ADRA Honduras prepared a number of teaching tools and manuals. These instruments were developed in cooperation with representatives from the MOH. The following manuals are used in training activities and are given to CHVs:

(a) *Mensajes Basicos De salud* (this flier has gone through several stages of development **(See Appendix 3).**

(b) ***Manual Para Personal Voluntario*** deals with four special topics: ***Nuticion; Infecciones Respirator&z Agudas; Manejo de Diarreas y uroc; Salud Reproductiva y Planificacion Familiar*** presented in four different manuals **(See Appendix 4).**

(c) ADRA Honduras is in the process of preparing a training manual on Vitamin A.

(3) ***Management Information System-***
The project developed a MIS to meet CS reporting requirements for ADRA International and USAID. The same MIS is used to report to CESAMO and the MOH (See **Appendix 5).**

(4) ***Survey Work-***
Developed and conducted a baseline survey with the technical assistance of Dr. Victor Lara, Survey Trainer, Johns Hopkins University **(see Appendix *L--Report on Baseline Survey).***

(5) ***Charts--***
ADRA Honduras was able to secure a set of flip charts from the MOH for teaching purposes but had to prepare additional charts for volunteers.

(6) ***Signs-***
ADRA Honduras supplied each volunteer with a sign that identifies her home as a "Health Volunteer," "UROC unit," and "Weighing Station" **(See Appendix 7--*CHV's Home Identification Signs).***

(7) ***Equipment and Supplies-***
ADRA Honduras secured 70 scales for the CHVs (50 foot scales, 20 children scales). Every CHV received a notebobk, pencil, and file holder.

(8) ***Equipment for VROC-***
The ministry of health is testing the possibility to establish special ORT centers with CHVs throughout the communities. On a trial basis CHVs were trained especially in ORT treatment. ADRA provided supplies for 6 stations (pan, water holder, 2 glasses, 2 spoons, 1 plastic tablecloth).

C. Outputs

As a result of the training sessions described above, the following statistics have been made available through ADRA Honduras (as of May 3 1, 1994):

14 supervisors trained (6 selected for ADRA work)
136 Community health volunteers trained
1,622 mothers educated
2 doctors and 1 nurse from CESAMO trained

d. Outcomes

Within the 10 months of active training and supervision through the CHVs the following measurable results can be reported (It has to be kept in mind that 17 months of project activities are still planned under the present funding cycle):

Objectives	Outcome
(1) ***Breastfeeding:*** To increase the percent of children less than 4 months that are being exclusively breast feed, from 19% to 60%.	34% of mothers are breastfeeding. [36% of goal reached]
(2) Weaning: Increase the knowledge of mothers with infants from O-23 months who know that solid/semisolid food should be given at 4-6 months from 50.3% to 80%.	3 17 mothers with children O-6 months received education to introduce solid food in babies. [No KAP data available]
(3) ***Growth Monitoring:*** To increase the number of children O-24 months who have a growth monitoring card and have been weighed in the four preceding months f?om 30% to 80%.	45.7% of children are weighed monthly. [3 1.4% of goal reached]
(4) Vitamin A: Increase the percent of infants 12-60 months who have received a megadose of Vitamin A during the past 6 months to 80%.	93% of children under 5 yrs are receiving Vitamin A. [goal reached and exceeded]
(5) Immunization: Increase the percent of children 12-24 months of age who are fully immunized from 66.9% to 80%.	93% of children less than 2 years are completely immunized. [goal reached and exceeded]

(6) Antenatal Care:	
To increase the percent of mothers who recorded at least one prenatal visit during their last pregnancy from ***49.2%*** to 60%.	100% (37) of all pregnant women have had prenatal care. [goal reached and exceeded]
(7) Birth Spacing:	
Increase the percent of mothers who wish to delay their next pregnancy by two years who use a modem biih control method from 28% to 40%.	[No KAP data available]
(8) ORT:	
To increase the percent of children with diarrhea during the last two weeks who were treated with ORS from ***39%*** to 60%.	98.2% of children with diarrhea (during last two months) were treated with ORT (212 cases reported, 208 treated by UROCs, 4 referred to CESAMO). [goal reached and exceeded]
(9) Home Management of ALRI:	
Increase to 60% the mothers of children less than 5 years of age who are able to recognize two major signs of pneumonia.	[No data available]
(10) ***Income Generation:***	
Increase to 10% the number of target households involved in income generation activities.	35 families out approx. 3,000 families are involved in income generation activities (goal of 300 families can be reached only if resources become available). (SED is not funded through CS money)

Note: In the absence of a KAP survey, the project is not able to measure the knowledge gained and the application of that knowledge in a day to day life situation.

There exists a discrepancy between the English and Spanish version of DIP on ORT. The project is measuring "children with diarrhea treated during the last two months" instead of "the last two weeks."

e. Primary Beneficiaries Reached

The primary target groups in the CS project area are mothers who are in their child bearing age, infants and children. Many CHVs do assist other persons also.

The DIP lists estimates of the age of the beneficiaries as:

Infants, O-l 1 months	831
children, 12-59 months	3,083
children, 60-70 months	760
females, 15-19 years	1,158
females, 20-34 years	2,298
females, 35-49 years	1,215
additional births yr 2 & 3	1,215

The project staff works with the following target (beneficiary) numbers (though they do not know where the DIP numbers come from since no source reference is given the numbers are close to reality).

Number of infants (O-l 1 mo)	:	830
Number of children (l-5 yrs)	:	3,083
Number of mothers		4,171

d. Comparison between Target Population and Reached Beneficiaries

The target population that the project works with comes from the CESAMO's census. ADRA Honduras is working with mothers that have children or are pregnant. They have not yet started to work with women that are not pregnant (nor with women that have no children between ages O-5). As mothers come to weighing centers of ADRA they receive instructions through the CHVs and supervisors. At this stage ADRA has not reached beyond the women who are present at these meetings. ADRA wanted to reach first those most "at risk." For the rest of the project time ADRA will extend its outreach to all women identified as beneficiaries.

		Target Population	Beneficiaries
Number of infants (O-l 1 mo)	:	830	920
Number of children (l-5 yrs)	:	3,083	2,842
Number of mothers		4,171	1,622

For a progress report (in Spanish), see **Appendix 8.**

2. Relevance to Child Survival Problems

What are the major causes of child mortality and morbidity in the project service area? What are the child survival interventions and health promotion activities initiated by the project? Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources available to the project and the community? Is the focus or prioritization of interventions appropriate?

a. Causes of Child Mortality and Morbidity

No specific data on child mortality and morbidity for the CS project area have been collected. Statistics for the Tegucigalpa metropolitan region are available but these composite statistics do not accurately describe the marginal areas as the colonies in which CS activities of ADRA Honduras are implemented.

For example, the composite IMR for the Metropolitan health region is 59 per 1,000 live births. However, government MSPH statistics show that the IMR exceeds 100 per 1,000 live births for Honduras households with no ready access to potable water, adequate sanitation and maternal education higher than grade 5. These are good descriptions of the households in the project areas.

Diarrhea and Acute Respiratory Infections are the highest causes of child morbidity. The *Encuesta Nacional de Nutrition* of 1987 showed that ARI represented 3 1% of reported illness, calculated on the number of diarrhea episodes in the 15 days prior to the survey. 60% of women in the project area did not receive even one antenatal consultation. 66% of children under one have not been vaccinated against measles. Nutrition deficiencies are a related cause in 60% of under-one deaths in the project area (see Baseline Survey, p. 1).

b. Interventions

The project proposal targeted the following CS activities:

Growth Monitoring/Nutrition :	30%
ORT	20%
Acute Respiratory Infections :	20%
Immunization	10%
Maternal Care	10%
Vitamin A	10%

The project approach is to reinforce the community organizations and household ability to prevent basic mother and child health problems, increase their knowledge and modifying their practices. ADRA is involved in strengthening the MOH primary health care services by

providing managerial/logistic support and technical training for MOH (CESAMO) personnel and thus improve capacity to implement PHC in cooperation with communities (to ensure that programs continue after project assistance is phased out).

c. Annrom-iateness of Mix of Interventions

The mix of interventions is appropriate to address the key questions of ARI, diarrhea and malnutrition. EPI, breast feeding, and nutrition are the right mix of interventions to address the problem of respiratory infections. It has to be stated that ADRA is not involved directly in many of the CS activity. It is clearly the responsibility of the government health clinics to administer and monitor these activities. ADRA's role is to support and assist in the supervision and referral of patients to the clinic by the trained CHVs.

The local community health center directors feel completely satisfied with the assistance provided through the CHVs and ADRA's supervisors. They see them as complementary and not as substitutions to the local health center staff

d. Appropriateness of Focus and Priority

According to statements made by both community health center directors, ADRA's focus is right on target, because ADRA does not duplicate but compliment government services. They commented especially on ADRA's attempts to place the work of the community volunteers on a sustainable basis (by involving them in micro enterprise projects allowing them to be financially independent from ADRA and the MOH). **See Appendix** 9 for a description of SEDs.

3. Effectiveness

What is the relationship between accomplishments for this period and objectives for this period? Has there been sufficient progress in meeting stated objectives and yearly targets? Are targeted high-risk groups being reached effectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

a. Target vs. Accomplishments

The project is funded for 36 months (Oct. 1, 1992- Sept. 30, 1995). 53% of fbnding time has passed. During the next 17 months ADRA Honduras has to accomplish the rest of its objectives. From the answers in question 1 .d above ADRA Honduras has achieved (and exceeded) some of its "mid-term goals," but clearly has to focus more on others. Considering the late start in the field work ADRA Honduras has to potential to reach most of its objectives by the end of the project's funding.

b. Progress Statement

It has to be pointed out that the following intervention schedule had been set by ADRA Honduras through the DIP:

June 1993	Begin nutrition improvement including promotion of exclusive breast feeding, appropriate weaning foods, growth monitoring, management of high risk children, and Vitamin A supplementation as well as immunization promotion/referrals.
June 1993	Improved care of mothers including promoting antenatal care and birth spacing.
act 1993	Control of Diarrheal Diseases (CDD) - promoting ORT and improved sanitary/hygiene.
act 1993	Income Generation (SED) - organizing management committees and administering revolving loan funds for income generating projects.
Jan 1994	Acute Lower Respiratory Infections (ALRI) - promote early recognition and rapid referral to CESAMO/ hospital facilities for treatment.

Based on that self imposed time schedule ADRA Honduras has achieved considerable progress. Many interventions are on target, Others seem to be questionable (based on the assumption that only 47% of the project time remains available).

In the absence of a RAP survey, it is difficult to assess the knowledge of mothers. All the mothers received the education. The ADRA CS project administration is only guessing that maybe the RAP factor is 40%. If such is the case, the project has made enough progress to achieve the objective at the end of the project. (But it is highly recommended that simple RAP surveys be conducted at least quarterly).

All mothers have a weighing card for their infants. But only 45.7% of the mothers are weighing their children and using the card. This means that 36% of the objective has been reached. At this rate the objective may not be reached at the end of the project, unless the project sensitizes more mothers to come to the weighing sites to weigh their babies.

In the Vitamin A intervention, 93% of the children more than 6 months of age are taking Vitamin A every six months. This objective has been far surpassed.

In the area of immunization, 93% of the children less than 2 years of age are completely immunized according to the requirements of the MOH. However, the project continues to work with the new arrivals.

In terms of maternal care, 100% of pregnant women (37) have seen the doctor at least once. This objective has been succeeded.

In the area of diarrhea control **98%** of cases during the last two months have been given ORT. (See discrepancy of months vs. weeks pointed out in note in answer 1 .d.) The objective has been surpassed. (The 2% of untreated cases were the ones referred to the CESAMOs because they were Plan B cases.)

c. High-risk Groups

High-risk groups are being identified and referred to the community social workers and CESAMO doctors. CHVs are encouraging mothers to use available resources through the health centers (there is for example a monitory incentive through the government if the mother weighs her child monthly; malnourished children can receive government subsidized food).

d. Constraints

Over most of the constrains ADRA has very little control (see described in section 2 above and 4 below).

4. Relevance to Development

What are the main community barriers to meeting the basic needs of children? What has the PVO project done to date to increase the ability of families to participate and benefit from child survival activities and services? Is the PVO fostering an environment which increases community self-reliance, and enables women to better address the health and nutrition needs of their families?

a. Community Barriers

Low economic resources; unemployment (estimated to be over 50%); high cost of living; illiteracy of mothers (staff estimates that 36% know how to sign their name, whereas baseline survey suggests that 82% are literate); single mother households (absentee fathers); alcoholism; drug addiction (many anecdotal stories were shared); lack of sanitation (toilets and potable water, in spite of past campaigns by FHIS to install toilets); substandard housing (cold, insecure, overcrowded); large families; live-in animals; closeness to the river (environmental contamination) to mention only the most obvious.

Initial community barriers existed against ADRA, because the organization was not known to the people (the fear existed, that giving the names of children would make them targets for adoption).

b. Increased Benefits through CS Activities

CS interventions existed before ADRAs project started to operate in the area. The government provides all the interventions through their centrally located CESAMOs. The weakness in their system has been the lack/absence of CHVs who could monitor the at-risk population in the communities. Although the government has occasionally trained CHVs, little supervision and continuous upgrading had been available to them prior to ADRA's involvement.

Now mothers have to go first to a CHV (who will fill out a referral slip) if they want to receive immediate attention at the health center. Currently, health centers are less overcrowded (because simple cases are diagnosed and treated by CHVs in the home) and urgent cases receive treatment at the CESAMOs.

CESAMO community social workers are not heavily overworked, because CHV are already screening the most at-risk people. Social workers follow-up only at-risk cases.

c. Community Self Reliance

ADRA's goal has not been to establish a new health system in the communities, but to strengthen the existing system. CHVs are not given any financial or commodity reimbursements for their

community involvement. Free training (and up-grading) is the most important incentive for the CHVs. This has been stated by most CHVs interviewed throughout the whole evaluation.

A number of micro-enterprise projects have been established through funding received from EMMAS (the National Committee for Social Welfare which receives funding from national budget appropriations). 4 out of 10 approved projects are functioning (3 additional ones have been organized and are ready to start; another 3 are planned to be organized; 20 additional have been approved by the government and are awaiting funding.)

Intensive family gardens are being promoted to allow mothers to grow nutritional vegetables (especially with Vitamin A). ADRA funded the training of 17 people (including 6 supervisors, 6 CHVs and 5 CS project staff) for 4 days. The training was conducted at the Pan American Agricultural School in Olancho by "Meals for Millions." Afterwards 14 additional volunteers were trained by the ADRA staff Seeds were provided through ADRA Honduras. This initiative started only in April 1994. No tangible effects can be reported at this stage except that 14 family gardens have been planted. Most of the plots are very small. Additional methods of how to make them more acceptable and productive should be explored. ADRA Honduras should set an example by using its relatively large plot in front of the office to establish a demonstration garden.

Supervisors organize with local community leaders occasional **garbage cleanup** campaigns, in which police and military assistance has been provided (especially in transporting trash).

5. Design and Implementation

Are there any particular aspects of project design or implementation which may be having a positive or negative effect on meeting project objectives? Please take into account the following:

5.1 Design

Has the project limited its project area or size of impact population? Has there been a careful expansion of project service activities? Has the PVO set measurable objectives of outputs and outcomes? Has the project management been willing to make changes when appropriate, and can the PVO justify or give a reasonable explanation of the directions and strategies the project has undertaken?

a. Area and Population

The catchment area consists of 6 densely populated urban areas. Most of those *colonias* have been formed by migrants from rural areas. (Source: CESAMOS' CEFASA (*Censo Familiar de Salud* - Yearly Family Health Census):

Flor de1 Campo :	6,317
Rodas Alvarado :	2,828
Las Torres	2,358
La Rosa	2,952
San Francisco :	5,929
La Soledad	2,616
Total :	23,000

The enclosed map **(Appendix** 9) indicates only the approximate location of the project site in the larger Tegucigalpa area. No detailed road map for the project area is available.

b. Expansion of Activities

There has been an expansion of activities. ADRA phased in its services and activities (they started with ORT training and breast feeding promotion, followed with growth monitoring, ARI, immunization promotion, and distribution of Vitamin A). Since March 1993, SED projects were established and ADRA is pilot testing UROCs (these are special ORT treatment centers) since April 1994. The expansion of interventions was done gradually to ensure that supervisors and CHVs feel comfortable with each new aspect of the CS activities.

The training of CHVs was also done gradually. The training activities in the San Francisco area was done in two separate sessions ("modules") to ensure proper understanding (most of the *CHVs* have *only primaria*--6 years education).

ADRA Honduras believes (and this was confirmed through interviews with CESAMO staff) that this gradual phasing in of activities accounts for much of their success.

c. Measurable Objectives

The objectives that ADRA has set are all measurable. The only problem is that ADRA often cannot measure the acceptance and practice of material taught. Additional attention should be given in designing and using simple KAP tools to measure every three months at random the knowledge of mothers and CHVs. Some tools are already developed by the training coordinator **(See Appendix 11: *Pre-Post Test-Infecciones Respiratorias Agudas*)**.

6. Changes Implemented

The following changes were implemented since the project was designed and the DIP was established:

(1) MIS coordinator was replaced with present one, to ensure proper information data (Feb. 1994).

(2) The health coordinator changed from a nurse to a medical doctor who had 7 years experience as a physician (two years in a CESAMO and CESAR). The new health coordinator works also as the MIS coordinator **(see Appendix 12 - *Curriculum Vitae).***

(3) A new training coordinator was chosen. She worked prior to her present position as a field supervisor. She has the educational as well as organizational qualifications to coordinate **the** SED **(EMMAS)** as **well (see Appendix 12 - *Curriculum Vitae)* .**

(4) ADRA proposed to train 215 volunteers (each one trained in only one special intervention). The MOH insisted that each CHV should be trained in all interventions (this justified the reduction of CHVs trained),

5.2 Management and Use of Data

Is the project collecting simple and useful data? Do the indicators need refinement? What is the balance between qualitative and quantitative methods of data collection? Is the project using surveys for monitoring and evaluation? How were baseline data used for project development? Are data being used for decision making? (Please give examples).

Is the project's routine health information system fully functional? Do the local staff have the management and technical capacity required to maintain the health information system? Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members? Is the PVO, headquarters and/or field, institutionalizing lessons learned by documenting, incorporating and sharing?

a. Data Collection

The data collected and the forms used for that collection are simple. ADRA Honduras is using most of the forms established and tested by the MOH. Its own forms are all coordinated with the CESAMO data needs as well. The forms have been refined at each stage. The government wants ADRA Honduras to use its own forms, especially the monthly volunteer reports (See **Attachment 13 - *Monthly Progress Reports).***

Indicators were already refined for the first Annual Report 1993 (with assistance from ADRA International). No further revisions are necessary (referral forms from CHVs to CESAMOs are already in the process of change).

The balance of various forms of data is sufficient (except that the MIS should include a 3 month . KAP survey to monitor knowledge as well practice).

b. Baseline Survey

ADRA Honduras had training and technical assistance for an extensive baseline survey (through Dr. Victor Lara, Survey Trainer, Johns Hopkins University). The baseline data was used to produce the DIP and to set realistic objectives. The final baseline report, prepared in Feb. 1993, was available to the ADRA Honduras project only in May 1994 (and that only in an English version). The project has been working with a partial tabulation of the survey.

A recommendation to ADRA Honduras is to teach volunteers how to draft graphs and charts so that they can "see" how their communities are progressing.

c. Health Information System

All forms in the HIS are ready and fully functional. The staff is fully qualified. The MIS coordinator is trained in WP, Harvard Graphics, Excell, DBase, Lotus 123, Form Tool, PrimMaster, some EPI Info. She is producing excellent charts for reports.

d. Sharing of Data collected

Data is shared with CESAMOs. Monthly reports are also sent to the regional health office, *patronatos*, ADRA International and AID Honduras. At the end of the year all the PVO's in Honduras share their reports. Data is also shared with supervisors and volunteers (monthly meetings). Community members are informed through supervisors.

Data has become an important tool for decision making. The training coordinator wants to use newly developed KAP instruments for determining training needs.

5.3 Community Education and Social Promotion

What is the balance between health promotion/social mobilization and service provision in this project? Is the balance appropriate? Is education linked to available services? Has the project carried out any community information, education, or communication activities? Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages? Have the messages been tested and refined? How does the PVO ensure that messages to mothers are consistent?

Does the project distribute any printed materials? Did the PVO pre-test printed materials? Do members of the community regard these materials as simple, useful and of value? Has the project been creative in its approach to community education, such as incorporating any non-traditional or participatory education activities? Has the project assessed the level of learning that has occurred with these methods, or is the evidence for effectiveness anecdotal?

a. Health Promotion and Social Mobilization

Clearly ADRA's main emphasis is on health promotion. But ADRA Honduras also admits that health promotion alone will not make a lasting impact on the community. Therefore, a number of vital elements of social mobilization are woven into ADRA's work in the CS activities.

(1) Community Health Volunteers are seen as the key element in ADRA's approach. The main promoters of health are community based. They have been selected because of their expressed and proven interest in the well being of their own community.

(2) The CHVs are not paid for their involvement in community health promotion. In the past, attempts were made to reward these CHVs either through monetary or commodity incentives. Most of these schemes failed after funding for those "payments" ceased.

(3) ADRA's emphasis is on education and supervision. CHVs receive a training through the program that gives them status in the community, because they now can make a meaningful contribution to the people in need. This has been mentioned many times by CHVs during the evaluation visits. Many of the CHVs have now become leaders among the women in the community. They "negotiate" with the communities traditional and political leadership for some of their "rights. "

(4) The reward for their involvement in the community is not a training in health promotion alone. ADRA has established SEDs, community banks and family gardens. These allow the CHVs to gain knowledge to establish and "run their own business. " Many times they have expressed pride in this fact.

(5) Most of the CHVs interviewed no longer thought in terms of relief but in terms of development. It is quite possible to see that many of the CHVs, become in the future, "voluntary supervisors" of the project.

ADRA Honduras's balance between health promotion and social mobilization is very much appropriate. It is exciting to see such an approach in CS activities is being promoted by ADRA (sometimes it seems unintentionally). Through this evaluation process ADRA Honduras came to realize more fully the implication of some of its initiatives.

b. Community Education

The key element in Honduras' CS program is the community and education. It is true that they coordinate very closely with the CESAMOs, but this is done for the sake of providing better services to the people in the community. This is accomplished by training volunteers that have gained *the* respect and moral support of the *patronatos* in the city blocks. It is through the CHVs and ADRA supervisors that the training is brought down to the level of the individuals in the community. (The community will much easier accept teachings from their own people than from an outsider coming into the community).

c. Development of the Message

ADRA Honduras in its initial stages has relied extensively on MOH material and CESAMO staff experience in the development of their educational material. The new training coordinator is testing mothers and community volunteers for what they consider are important issues in their lives. Constant pre- and post-tests at training sessions will be essential in understanding how the community thinks and what is essential to them. It is believed that if ADRA Honduras will

utilize the knowledge gained through these surveys their curriculum will become much more practical and community based.

ADRA Honduras, CESAMO and CHVs meet monthly at either a community center or the CESAMOs to discuss issues of mutual concern and to continue training. These sessions have become a source of important information and fine tuning of training needs. These sessions also insure that all people involved teach consistent messages throughout the project area.

d. Teachinn Material

The ADRA project is producing and distributing printed material mainly to its CHVs. The material has been described above. It has gone through several stages of development, every time incorporating lessons learned from previous training sessions. Material has always been developed in coordination with the MOH. The fact is, that not enough material is available locally. ADRA has been able to use its resources to duplicate and distribute much of the material in its area.

The material is being used extensively not only in training sessions, but also in the community. Most of the material is well used.

The evaluation team has made suggestions to use more practical lessons in training, where CHVs can learn to do things under the direct supervision of the trainer. Furthermore, possibilities should be explored to use skits and dramas to train community members in public performances.

e. Learnina Assessments

With the arrival of the new training coordinator (who had worked for several months prior to that assignment as a field supervisor), KAP tools in each area of instructions are being developed. She is also developing material in complementing and reinforcing material taught in training sessions. She is preparing a monthly newsletter, evaluation tool to be used to test supervisors and CHVs periodically, and evaluation/training tours where personnel can observe other projects. **(See Appendix *14* - *Training Outline and Assessments).***

5.4 Human Resources for Child Survival

How many persons are working in this child survival project? Does the project have adequate numbers and mix of staff to meet the technical managerial and operational needs of the project? Do these staff have local counterparts? Are community volunteers taking part in this project? How many are in place? Are they multi-purpose workers or do they concentrate on a single intervention? Is their workload reasonable? How many days of initial training and how many days of refresher training have they received since the start of the project? Is there evidence the PVO carried out a needs assessment before embarking on initial and refresher training? Was the training methodology appropriate for the nature of the health workers jobs? Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

a. ADRA Employees

ADRA Honduras has 14 employees. They could need 2 more supervisors because the Flor de1 Carnpo colony is spread out over a relatively large area. The whole territory is not yet included in the CS activities. Requests have been made to extend to the whole area. Workers are qualified for their responsibilities. Most employees **are** women **(see Appendix 15 - *CS* Project *Personnel*** and **Appendix *16 - ADRA Honduras CS Organizational Chart).***

b. Cornrnunity Counterparts

ADRA Honduras CS activities are mainly playing a support role to the community health services of the government. Two CESAMOs are responsible for the health services in the project area. Each CESAMO has a large support staff. There are 9 employees (at the two CESEMOs) that work very closely together with the CS program of ADRA (two center directors--Ml%, 2 social workers, 1 educational offices in Flor de1 Campo CESAMO, 2 nurses and 2 auxiliary nurses).

c. Community Volunteers

136 Volunteers have been trained and are working. 40 more were recruited and have received the first training (they need one more training session of one week). The new trainees will be used to strengthen other geographical areas that need extra CS involvement and know-how as well as for replacement of drop-out CHVs.

CHVs are working in all CS interventions. The original plan was to train them in single intervention skills, but the policy of the MOH is to have CHVs trained in multiple intervention skills. Their work load is reasonable. The number of mothers per volunteer averages 25. They could handle up to 30 mothers.

The volunteers have been supplied with a folder containing record keeping and reporting forms. They have supplies of Litrosol and condoms. If they are a part of a weighing team they have scales.

The training coordinator has developed tools to assess knowledge gained and knowledge missing after each training course. A regular training newsletter to the CHVs is reinforcing some of the lessons taught in the training sessions **(see Appendix 14 - *Entre Mujeres*)**. ***KAP*** tools are being prepared to assess knowledge retained for each intervention subject to be administered to CHVs on a regular interval. The results will determine what training is necessary (supervisors are expected to provide on the job training after administering RAP test if understanding is lacking).

The initial training for CHVs was 40 hours (for supervisors 80 hours). But it is the feeling of the staff and the CHVs that they need continuous reinforcement of matters taught (plans are in place for continuous upgrading).

5.5 Supplies and Materials for Local Staff

What educational or other materials have been distributed to workers? Do these materials or supplies give any evidence of being used? Are they valued by the health worker? Are they appropriate to the health worker's job? Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?

a. Supplies

Each CHV receives 25 packages of Litrosol. Whenever they have less than 5 packages, they receive more packages (from CESAMO, supervisors, or at weighing session). They have a supply of condoms which is available to them at the CESAMO. Some CHVs indicated that they have their own supplies of teas which they sometime administer to sick children.

Each CHV has received also a supply of folders and pencils. Each of the 6 UROC sites have received supplies described above.

b. Training: Materials

Since this is ADRA Honduras's first round of CS work, the initial training material and hand-outs came from projects like HOPE, FIO, ADRA Nicaragua (CS), and ADRA International. Additional material (like posters and flip charts) came from the MOH (none of those are included in this document).

Recently, the ADRA Honduras has prepared its own training manual. 250 sets (4 manuals in each set) have been prepared and distributed to CHVs, supervisors and CESAMO staff These manuals are used extensively by personnel. The material has been approved by the MOH.

c. Identification

Each CHV's home is identified with a sign as a health post **(see Appendix 7 - *Home Identification* Signs)**. These signs have the approval by ADRA Honduras and the MSPH of the MOH. Identification cards are also issued to volunteers which gives them preferential treatment not only at the CESAMOs but also in other government offices (see **Appendix 17 - *CHV's Identifications).***

5.6 Quality

Do the local project staff currently have the technical knowledge and skills to carry out their current child survival responsibilities? Do the local staff counsel and support mothers in an appropriate manner?

a. Quality of Staff

The CS director is a trained administrator. He has 20 years of experience in community work. He has received special training in CS activities.

The health and MIS coordinator is a trained medical doctor with 7 years of experience in general medicine and 7 years of experience in computing. She worked for two years as a physician of a CESAMO as well as a resource physician to a CESAR.

The training coordinator has a Bachelor of Science in economics. Her research project was on women and SED. She has been promoted from field supervisor to her present position at the beginning of this year. This field experience is benefiting her in her present assignment.

The accountant has 20 years of accounting experience. She received training in the use of the AAA accounting system used by ADRA International for CS projects.

The secretaries are trained beyond the secondary course. One has 10 years of experience and is bilingual (this is of benefit because ADRA Honduras deals with English speaking entities). The other secretary has 2 years of experience. Both are trained in computers.

The supervisors have received complete training in CS activities together with refresher courses in each of the CS interventions. The supervisors are mostly trained professionals (nutritionist, university student, assistant nurse, teacher, commercial studies graduates).

b. Working Relationshins with Community

During monthly meetings the staff advise the mothers regularly. They also advise mothers at the weighing sites. CHVs work very closely with mothers throughout the immunization campaigns. Special celebrations in the communities are planned together. The work schedule of the supervisors corresponds to the mothers' activities.

5.7 Supervision and Monitoring

What is the nature of supervision and monitoring carried out in this project? Is it field-based supervision? Has supervision of each level of health worker been adequate for assuring quality of services? From the viewpoint of the health worker, how much of the supervision is counseling/support, performance evaluation, on-the-job education, or administration? What are the monitoring and supervision requirements for the remainder of the project?

a. Supervision

The project director is responsible for the overall supervision. He has delegated training responsibilities to the project's training coordinator and technical health issues to the health coordinator. Data collection for management decisions is done by the MIS coordinator.

The coordinators work very closely with the supervisors (the project director is also present at monthly community meetings. He is also involved in the supervision of the SEDs).

Indirectly CESAMO assists in the supervision of ADRA's field staff. The supervisors especially interact daily with the CESAMO social workers. Their activities are coordinated and checked constantly for compliance with government regulations.

b. Monitoring.

The performance of each worker is done not only by field observations but also periodic reports. **(See Appendix 13 - *Reports.*** The field visits verify what the reports say.) Performance is monitored by a combination of field and office supervision.

The project director meets with the coordinators and supervisors daily at the office. (Field visits take place 3 to 4 times a week.) Coordinators visit the field daily. The supervisors spend 6-7 hours in the field daily. MOH representatives see this as ADRA's greatest strength. It allows close supervision of CHVs and coordination with CESAMO.

No additional supervision requirements are envisaged for the rest of the project, The level of supervision seems adequate.

5.8 Use of Central Funding

Have administrative monitoring and technical support from the PVO regional or central offices been appropriate in terms of timing, frequency and needs of the field staff? If not, what constraints does the project face in obtaining adequate monitoring and technical support from PVO regional or central offices?

How much central funding has A.I.D. given the child survival grant for administrative monitoring and technical support of the project? Do these funds serve a critical function? Do this function appear to be underfunded or overfunded? Are there any particular aspects of A.I.D. funding to the central office of the PVO that may have a positive or negative effect on meeting child survival objectives?

a. Central Office Support

ADRA Honduras has been new in the implementation of CS activities. No prior CS activities had been in operation with the exception of hospital work in the rural area around Valley de Angeles, 15 miles outside of Tegucigalpa. ADRA Honduras's experience has been with Matching Grant activities previously funded by USAID. Those activities were limited to rural agricultural work. For that reason ADRA Honduras needed and received considerable help from ADRA International, ADRA Inter-American Division (Miami), and ADRA Central American Union (Costa Rica). See next question for a list of technical visits.

b. Administrative Funding

ADRA Honduras CS project gets technical and administrative assistance from ADRA International, which has its own headquarter's budget. The local operations are funded through a local budget. The following financial resources are set aside for management, technical assistance and evaluation (for the whole budget see question 10, Pipeline Analysis, below):

	A.I.D.	PVO	TOTAL.
HEADQUARTERS			
Evaluation	1,018		1,018
Program costs			
A. Personnel			
1. Technical	5,571	3,292	8,863
2. Administrative	10,994	3,289	14,283
3. support			
B. Travel			
1. In country			
2. International	11,516	1,422	12,939
c. other Direct cost	6,823	1,627	8,450

FIELD			
Evaluation	2,913		2,913
Program Costs			
A. Personnel			
1. Technical	29,429		29,429
2. Administrative	32,330		32,330
3. support	14,700		14,700
B. Travel			
1. In Country	3,071		3,071
2. International			
C. Other Direct Cost	38,965	27,350	66,315
D. Indirect Costs	27,446	5,724	33,170
TOTAL			
Total Headquarters	35,923	9,630	45,553
Total Field	148,854	33,074	181,928
Total	184,777	42,705	227,481

The above total $227,481 used for evaluation, technical and administrative is 40.2% of the total Honduras CS budget ($565,558).

C. Result of Funding

Having observed ADRA CS project initiation over the years, the launching of operations with a large influx of early technical assistance and training has paid off. ADRA Honduras has a good understanding of how to operate in the field, conduct training, and manage activities in the office. ADRA should be commended for this strategy.

Although a large amount of money was set aside for international travel in the field budget, this amount has hardly been utilized. ADRA Honduras personnel would benefit from observing CS activities in Nicaragua and other countries..

5.9 PVO's Use of Technical Support

What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained? Was the level of technical support obtained by the project adequate, straightforward and worthwhile?. Are there any particular aspects of the technical support (from all sources) which may have had a positive or negative effect on meeting project objectives? (For example consultant visits, evaluations, workshops, conferences, exchange field visits). Is there a need for technical support in the next six months? If so, what are the constraints to obtaining the necessary support?

a. External Technical Assistance

The primary counterpart in ADRA International is Mr. Milton McHenry. He is the CS Manager for Honduras in ADRA (Senior Manager). Technical personnel directly involved in CS assistance to Honduras from the central office has been Dr. Gerald Whitehouse (Senior Health Advisor) and Mr. Hugo de Leon (Senior Financial Advisor).

(1) ADRA International sent 7 persons in February 1993 to initiate the program (assisted in baseline survey, held an orientation workshop and helped write the DIP).

(2) The senior financial advisor trained the project accountant in the use of the AAA accounting system in April 1993.

(3) In May 1993 ADRA International's CS Manager provided further management orientation to the project.

(4) ADRA International's CS manager and Senior Health Advisor assisted in the preparation of the first annual report.

(5) ADRA International's Senior Accountant came to review the accounts for a pre-audit in October 1993.

(6) Honduras' CS project director participated in ADRA International's technical workshop held in Washington, DC, April 1994.

(7) Senior accountant from ADRA International returned for further review of the accounts in May 1994.

(8) ADRA Central American director and ADRA Honduras director visit periodically for administrative purposes.

(9) Permanent supervision from ADRA Honduras' director.

b. Assessment of Technical Visits

The initial training and counseling by ADRA International was based on their extensive experience in CS implementations in other countries. The Honduras project was not a new endeavor for them but they were flexible to learn from the given realities in Honduras. ADRA International invited and visited other local NGO's and other community people in order to get their opinions on CS issues.

Literature provided through ADRA International has been very useful. The visits are constant, the timing is appropriate. The only negative feelings ADRA Honduras has, is that some advisors

have shown a lack of confidence in the Honduras staff

c. Need for Technical Assistance

Ifthe present personnel does not change within the next 6 months no additional technical assistance is needed. But if changes would take place particularly among the coordinators, many of the gains made in the last 6 months would be lost to this project. It is advised that ADRA International monitor this situation very carefully.

It would be advisable to establish a team (combination of technical, financial and managerial personnel) that would come prior to final evaluation to make proper arrangement for the final evaluation as well as involve ADRA Honduras staff in a discussion of how to carefully enlarge the CS program (including in the area of AIDS as strongly suggested by the local A1.D office in Tegucigalpa).

5.10 Assessment of Counterpart Relationships

What are the chief counterpart organizations to this project? What collaborative activities have taken place to-date? Are there any exchanges of money, materials, or human resources between the project and its counterparts? Do the counterpart staffs have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities? Is there an open dialogue between the PVO project and counterparts?

a. Counterpart Organizations

Besides the ADRA partner levels (from international, regional, country), the project coordinates and cooperates with a variety of counterpart organizations:

(1) *Community Level:* This is the most immediate level of cooperation. Without doubt ADRA Honduras works together and reports activities to the local community leaders ***(patronatos).*** But the actual CS health initiatives are implemented in close cooperation with the CESAMOs (and especially their directors, and social workers) in the area.

The areas of collaboration include training, supervision of volunteers, coordination and planning (planning of training is done every week). The directors, coordinators, and supervisors meet regularly with their counterparts. The supervisors meet every day with the health coordinators of the CESAMOs to plan the activities for the day. Training for volunteers is done by ADRA Honduras in close collaboration with the CESAMO staff usually in a community center.

Each CESAMO has appointed an auxiliary nurse to work permanently with the ADRA supervisors in the field (these auxiliary nurses should later become the permanent supervisors of the CHVs). The ADRA staff meets monthly with the CESAMO staff and the volunteers (more than 90 people) on the premises of each CESAMO **(see Appendix** 18 - ***Relation CESAMO-ADRA).***

(2) ***Ministry of Health Level:*** In March 1994 the MOH appointed a ***Coordinator de Organization Privodas de Desarrollo la region de Metropolitana.*** He is the regional counterpart not only with ADRA but with all the NGOs working in the region. ADRA seems to have a very cordial working relationship with the director (a Medical doctor) because ADRA informs him regularly of its activities.

On the national level of the MOH, ADRA reports to the director of the Office of Public Health **(see Appendix 19 - *Relation ADRA-AreaMetropokna-MSPH).***

(3) *PVO Level:* ADRA Honduras has very close and cordial relationships with Project Hope, Save the Children, World Vision, FIO, Aldea Global, Population Council, etc.

Three inter-institutional committees coordinate the working relationships between the government and the PVOs (on the field, regional and national level) (See **Appendix 20** - ***Relation ADRA Con Otras OPD's***).

b. Joint Activities

The most important joint ventures during the last year have been a number of workshops and training sessions. Each time ADRA has a training session for its staff or the CHVs, staff from the CESAMOs as well as from other NGOs participate. Teaching staff from those other institutions have been utilized every time.

In the establishment of UROC centers, ADRA has very closely collaborated with CESAMO and other government agencies.

There is an exchange (sharing) of material such as manuals, charts, MIS papers, guides, newsletters, videos, projectors, films, and transport. Personnel from various organizations collaborate during immunization campaigns, training sessions, and during the technical committees often held at ADRA Honduras' office

c. Fiscal Relationships

There has been no exchange of money for those joint ventures, except for expenses of food during training sessions.

d. Qualification of Counterparts

The staff of the CESAMOs are qualified in the field of CS. The directors are medical doctors. The social workers have a university degree in social work. The nurses are government registered nurses. The auxiliaries are practical nurses. The training coordinator has been trained as a primary school teacher. They are all mature persons with at least 10 years of field experience in primary health care. ADRA Honduras has no doubt that they can continue the work in the field of training.

e. Coordination

The coordination between ADRA Honduras and its counterparts is strong, and goes from the MOH down to the CESAMOs. The dialogue is open and continuous. There is a desire on both parts to follow the general objectives of the MOH.

5.11 Referral Relationships

Identify the potential referral care sites and comment on access and service quality. Has the project made appropriate use of these referral sites? What is thecontinuity of relationships between the referral site and the community project? Is the dialogue between project and referral site adequate? Is the project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

a. Referral Sites

In the communities were ADRA is implementing its CS work, the referral system of patients starts with the CHV. They refer cases to the CESAMOs **(see Appendix 21 - *CHV's Referral Sip)*.** It is then the responsibility of the doctors or the nurses at the CESAMOs to refer the patients to the hospitals.

The following hospitals are the primary referral sites for patients from the CS areas: Escuela Hospitals (teaching hospital of the Medical University), San Felipe Hospital, the Thorax Hospital, and the Neuropsychiatric Hospital. The teaching hospital has a section called ***Hospital Matemo Infantil***--which is a hospital for mothers and children).

b. Accessibility of Referral Sites

Most homes in the project area are ***2-3*** km distance from the nearest CESAMO or CESAR. Roads and walkways provide easy access during the dry season. During the rainy season the roads can become slippery. There is no public transportation between the houses and the CESAMOs or CESARs.

The CESAMOs and hospitals offers medical attention at the rate of 30 patients per day per medical doctor. Medicine is distributed both at the CESAMOs and the CESARs. The health centers are open in the morning and early afternoon. After those hours patients have to go to the hospitals which are 8-15 km away. Hospitals are open for emergency services 24 hours.

c. Relationshin between ADRA and Referral Sites

Relationships to CESAMOs, ADRA's primary referral site, has been described above in detail. Working relationships with hospital sites do not exist. But CHVs have easy access to hospitals through their identification cards as community volunteers.

ADRA Honduras has worked out arrangements with the CESAMOs that a patient should come to the clinics with a referral slip from the CHV (in cases such as malnutrition in category B and C, immunization needs, fever, skin disease, prenatal care, pap-smear tests etc.). The volunteer has a 3 part paper slip as reference document. She fills in part I and part II. She keeps part I and sends part II and III along with the patient to the CESAMO. After attending to the patient, the medical doctor or nurse, completes Part III with instructions for the patients who takes it back to the volunteer. The volunteer follows up on the CESAMO instructions. Upon the patient's return she files part III together with part I. If the patient does not return she visits them.

d. Strengthening of Referral Service

One of the main objectives of the ADRA Honduras CS activities has been to strengthen the most vital link between the community and the primary referral site in the communities: CHWs and CESAMOs. According to the CESAMO directors this aspect of the project works satisfactory. According to the CHVs there is still a lack of CESAMO personnel sending the referral slip back with CHVs. ADRA is in the process of redesigning the referral slip **(see Appendix 21 - *Referral Sip).***

5.12 PVO/NGO Networking

What evidence is there of effective networking with other PVOs and NGOs working in health and child survival? Are there any particular aspects of the situation which may have had a positive or negative effect on networking? Can the project cite at least one lesson learned from other PVOs or from other child survival projects?

a. Networking

Section 5.10 (a) above has already describe the relationships with other PVOs in the implementation of CS activities. ADRA participates in all the NGOs monthly meetings. No negative aspects of such cooperation has been reported.

b. Examples of Cooperation

Not only do representatives from other PVOs participate in ADRA's activities, but the following examples indicate ADRA participation in activities of their partners in CS activities in Honduras:

(1) The health coordinator attended a project Hope seminar on how to tabulate home visit forms.

(2) She also went to a Population Council seminar on reproductive education.

(3) ADRA's project director participated in CS FIO DIP writing workshop.

(4) The whole StafFattended a World Vision seminar on CS sustainability.

(5) Seven ADRA CS project supervisors attended a seminar on ARI, given by Project Hope in March 1994.

(6) 13 ADRA staff members attended a Vitamin A seminar hosted by FIO in August 1993.

(7) The ADU project director participated in the end of CS project evaluation of Save the Children.

(8) The National Immunization Campaign brought all NGOs together twice in 1993 and once already in 1994. These joint meetings strengthened the working relationship among the various organizations.

c. Valuable Lesson Learned

Since home gardening is a vital aspect of CS activities in the Honduras project, ADRA wanted to learn how to integrate it into its work. At the Meals for Million Project ADU found valuable lessons of how to grow food on a very small piece of land. This has been valuable for work in urban settings were people often live in very crowded conditions.

5.13 Budget Management

How does the rate of expenditures to-date compare with the project budget? Is the budget being managed in a responsible, but flexible manner? Can the PVO justify budget shifts that may have occurred? Can the project achieve its objectives with the remaining funding? Is there a possibility that the budget will be underspent at the end of the project?

a. Analysis of Spending vs. Budget

Time: 53% passed	% of Budget Spent			% of Budget Remains			Total
Budgets--	A.I.D.	PVO	Total	A.I.D.	PVO	Total	
Headquarter	60%	56%	59%	40%	44%	41%	100%
Field	41%	27%	37%	59%	73%	63%	100%
Total	44%	30%	40%	56%	70%	60%	100%

Project activities have been taking place for 53% of project cycle already. At this stage of the activities:

- The headquarter's budget appears to be overall on target (except the PVO's proportion of budget contribution is falling short of target).
- The field's budget is underspent by 16% (falling short by 26% of PVO contribution to actual budget).
- The total amount spent in the Honduras CS operations (field and headquarter's budget) is only 40% of total budget (13% under "actual expenditure to date" budgeted).

The project should have spent by now more of its budget. Since most expenditures occur as start-up costs, there seems to be an underspending of funds.

Secondly, the PVO's contributions to the project have been falling short in headquarters as well as field amounts.

b. Management of Funds

ADRA International has provided extensive management training as well as accounting assistance during the last 19 months. The control of actual funds has been in the hands of ADRA board chairman. This practice is not appropriate and management of funds should be under the control of CS project manager with appropriate accounting controls.

The project seems to be very frugal in the spending of money. The project managers are too cautious to expand the operations to fit the total budget so they have not yet reached the projects full potential.

Sufficient money is available to conclude the project. There seems to be enough money available to extend activities into other areas.

C. Recommendations of Budget

Since most start-up budgets should have been spent by now, the project activities do not match the project expense. ADRA Honduras shall prepare a work plan until the end of the project cycle that will take into consideration the available money, including PVO's own contributions. This will help avoid underspending of the budget by the end of the project.

6. Sustainability

What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?

Are the incentives received by community volunteers, project staff, and counterparts meaningful for project commitment? Would those incentives continue once A.LD. project funding ends?

How is the community involved in planning and implementation of project activities? Do community members see this project as effective? Is there a demand in the community for the project activities to be sustained?

Do local organizations see the project as effective? Are there any concrete plans for project activities to be institutionalized by local NGOs?

Is the MOH involved in the project? Does the MOH see this project as effective? Are there any concrete plans for the MOH to continue particular project activities after funding ends?

a. Incentives and Sustainability

CHVs are provided with the following incentives: Expenses and in some cases per diem for attending training, pencils and writing material, manuals, folders, seeds, access to credit through the SED, support when there is death in the family, priority of services when they go to the CESAMOs and the hospitals (through the use of their ID card, given by ADRA and signed by the CESAMO and ADRA directors).

CS supervisors attend seminars and conferences outside of ADRA, they receive: training, work material (pencils, manuals, paper), regular collations, transportation benefits, accident, social, and life insurance and diplomas in CS capability.

CESAMOs staff participate in training given by ADRA. They also receive manuals prepared and duplicated by ADRA. The participants receive expenses and food for the day. The rational of the use of these non-monetary incentives has been described earlier.

The provision of incentives like material, education, training, some food during seminars, will continue. The CESAMOs were already using these encouragements prior to ADRA's CS activities.

b. Local Organizations

ADRA has organized a Committee of Volunteers in Flor de1 Campo. This committee participates in planning of training and different interventions.

There are Mothers' Clubs in the communities. These clubs have not been organized by ADRA, but ADRA recognizes and uses the infrastructure of those groups. Some of their members benefit through the ADRA activities and ADRA helped the club to identify their target groups. Otherwise, ADRA is not working with them directly because their focus is not necessarily health related.

c. Acceptance of ADRA in the Community

The mothers are satisfied with the services provided by ADRA Honduras, especially through the work of the volunteers. The UROC and weighing stations have made access to health services easier, as well as less costly in time and money. The clinics have an abundance of Litrosol. They are also vital for health education. The mothers say that life has changed significantly in terms of health (less pneumonia case, less diarrhea cases, know how to control their pregnancies).

d. The Extension of the Project

The major request for the continuation of the project has come directly from the head of the MOH. Dr. Higuero made it clear that the PVO's are vital in complementing the work of the MOH. However, the MOH is not speaking of taking over the PVOs work, instead they want them to continue in their present role. Many of the mothers and especially CHVs who already clearly see that sustainability depends on the capacity of ADRA to help them to develop SEDs, that in turn will create the necessary resources for them to address their health needs themselves. They are now requesting (*Fondos Communales de Medicamentos),* popular pharmacies (basic medicines at an affordable price) with the help of UNISA and PRODIM.

e. MOH Involvement

The MOH is involved in the project, through the joint NGO Committees, and the CS Technical Committee. ADRA and the MOH coordinate their work in the field through the CESAMOs and CESARs. The MOH provides ADRA Honduras with material, manuals, charts, and videos. The MOH officials give public testimony of the work of ADRA in official meetings.

The MOH considers the work of ADRA as the most effective one among the other PVO's. In view of their lack of finds, personnel, equipment, the MOH sees ADRA as complementing their work. There is a desire to take over ADRA's work as soon as funds become available. They have appointed state paid employees to support, coordinate and learn from ADRA. The MOH director for NGO's activities, is trying to learn from ADRA of how to institutionalize the work of CHVs permanently.

f. Local NGOs

There are no local NGOs in the area, except organizations like the *patronatos*, health committees, volunteer committees, UNISA, and Rotary Clubs.

The best guarantee for the activities to continue are the volunteers committees. They have already indicated that they will continue on their own regardless of the presence of NGO's.

The Seventh-day Adventist Church has a network of Dorcas Societies Mothers Clubs whose members could be ready to sustain the work of the volunteers (if trained) whenever USAID funds end. The members of the Dorcas Societies live in the communities and are in direct touch with the volunteers.

7. Recurrent Costs and Cost Recovery Mechanisms

Do the project managers have a good understanding of the human, material, and financial inputs required to sustain effective child survival activities? What is the amount of money the project calculates will be needed to cover recurrent costs? Does the community agree to pay for any part of the costs of preventive and promotive health activities? Is the Government prepared to assume any part of the recurrent costs? What strategies is the PVO implementing to reduce costs and make the project more efficient? What specific cost-recovery mechanisms are being implemented to offset project expenditures? Are the costs reasonable given the environment in which the project operates; is the cost per potential beneficiary appropriate? Identify costs which are not likely to be sustainable.

a. The Management Capacity of Project Director

The project director has a good understanding of what it means to run a project. He has been able to surround himself with good coordinators. He supervises them well not only in the office but also field work.

He tries to work within the budget constraints and inflationary restrictions. He has been able to respond to the needs of the project. He is quite conservative in his fiscal responsibility. He has a lot of experience in finance management through his past work. Each year he revises the budget and organizes the expenses by quarters. A monthly report is made where he can determine the monthly expenses and the accumulated expenses over the life of the project. He monitors the funds carefully with the assistance of his accountant. He takes corrective measures whenever needed especially in the elaboration of the quarterly budgets **(see Appendix 22 - *Accounting Reports).***

b. Recurrent Costs

The following monthly recurring expenses are listed as administrative item:

Personnel	$4,314
Printing	$ 120
Communication (tel)	$ 124
Vehicle	$ 201
Insurance	$ 297
Rent	$ 152
Utilities	$ 4
Supplies	$ 152
Medical	$ 185
Incentives	$ 82
	$ 5,631

Training cost has to be included in this calculation. The amount depends on the extent and need for training.

c. The Community and Recurring Costs

The CHVs committees and the CESAMOs have already indicated that they will continue the volunteer health role in the communities. What they need is additional training in supervision and refresher training in specific CS health interventions. The auxiliary nurse from the CESAMOs assigned to ADRA Honduras CS operations should be upgraded through supervisory training to become a field supervisor for the CHVs. In that way the whole community involvement would be institutionalized into the CESAMOs.

d. Cost-recovers Mechanism

No cost recovery mechanism for the ADRA type of work is necessary. After a thorough training of CHVs who will have confidence in their skills and are therefore accepted by the community and recognized by the CESAMOs, the project can very easily taken over by the MOH and ADRA can move into new territories of the Tegucigalpa suburbs (or get involved in additional development activities in the same communities).

Because the project start-up activities have been very intensive and therefore more costly, it is too early to calculate the cost per beneficiary at this stage. ADRA Honduras should have the chance to finish the project before such a calculation can be made realistically.

One important cost recovery has taken place on the CESAMO level. The community social worker is less involved in routine screening work of high-risk patients, but can now concentrate on follow-up of the most urgent children. This allows her to do a more thorough job (according to her own accounts). Furthermore, the CESAMO clinics are less crowded because minor cases have been treated already in the clinic. (The CESAMO directors have been able to recognize these changes already).

The greatest need for the project would be still to provide training material for all the CHVs.

8. Recommendations

What steps should be taken by PVO field staff and headquarters for the project to achieve its output and outcome objectives by the end of the project? Are there any steps the project and PVO headquarters can take to make the project activities more sustainable? Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the services of higher quality? Are there any steps the project and PVO **headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by A.LD., or by the PVO? Finally, are there any issues or actions that A.I.D. should consider as a result of this evaluation?**

An extensive set of detailed observations and recommendations has been prepared and has been presented prior to departure to the project staff(see **Attachment** 3). The following points are a summary of those statements:

a. Child Survival Staff and Program Implementation

The team was impressed with the openness with which the ADRA staff was involved in the evaluation process. The personnel changes that have taken place during the first part of the project have benefited the project. No further changes should be made. (If changes are necessary, it should be in such a way that the outgoing person can overlap with the new person for at least two months.)

Training is the key in ADRA's CS project. It is important that proper simple tools should be developed to measure the effect of such training and assess its future need.

b. Child Survival Program Design

One of the greatest strengths of the ADRA CS project is the fact that it has not tried to duplicate already existing services but is cooperating with the CESAMOs in strengthening the system of CHVs in a sustainable manner. Attempts should be made to phase out gradually one of the two supervisors assigned to specific areas and replace them with either very active and motivated CHVs or CESAMO staff

Greater attention should be given by ADRA International and USAID to Honduras' SEDs as a means of sustaining CHVs in CS activities. ADRA Honduras should document their work in community banking and small enterprise development in order to allow ADRA International to make a detailed study on the effectiveness of these programs.

The expansion of CS activities after the present funding cycle should be done cautiously. Additional elements very vital for primary health care services should be considered, such as sanitation, water and, foremost AIDS prevention.

c. Training

All of ADRA's staff should receive continuous upgrading in CS program skills and management. This can be done through training sessions provided by the MOH in the country as well as through visiting projects like the CS project in Nicaragua.

ADRA Honduras SED staff should have a chance to receive fiu-ther training in planning and proposal writing, but should also have the chance to share their own experiences with other SED implementors.

The training curriculum should shift from the present theoretical training to a more practical approach of CS interventions. New training approaches (like drama presentations) should be explored. The training should attempt to attract more men in order to incorporate them into the overall training needs of CS.

Although ADRA Honduras has been involved in hosting many training sessions, no indications of how much knowledge the people have gained is available. It is recommendable that KAP tools are in the process of being developed and used for pre and post training testing.

d. &plies for CHVs

ADRA should explore the feasibility of how to provide the CHVs with First Aid training and supplies so that they can treat minor skin wounds in the community to avoid infections. This training and work should be done in collaboration with the CESAMOs.

Training should be provided for CHVs and supervisors on how to prepare charts that can visually show the community how well they are progressing.

e. Working: Relationshins

Excellent working relationships exist with ADRA Honduras and the community health institutions. These relationships had to be built during the last few months. Similar cordial relationships should be attempted with the church constituency which could become a potential source of supporters of CS activities after the funding ceases.

f. Administrative Observations

The ADRA CS project director should become a co-signer of the CS bank accounts. This will allow proper control of CS finances.

A travel log should be kept on the daily use of the CS vehicle. No travel unrelated to CS project activities should be permitted.

g. Project Conclusion

ADRA Honduras has sufficient resources to bring the project to a conclusion at the end of the three year period. Because of unexpected high inflation in Honduras a revision of the budget should be granted. A revised budget should be submitted to ADRA International by July 15, 1994 for approval.

It is recommended that this project should apply for another three years of CS finding if qualified personnel will continuously be available in order to:

1. Reach target population, not only beneficiaries
2. Reach all target areas
3. To reach beyond the current target area that is not covered by any CS activities
4. To further expand SED activities and allow income generating activities will become more valuable and more sustainable and thereby allowing CHVs to be more independent from external funding

h. Future Evaluations

Future evaluations should not rely on MOH and A.I.D. full time participation. Those entities can not be expected to be involved throughout the whole process of project observation and report writing.

That at least 2 weeks be allowed for mid-term evaluations and three weeks for final evaluation to satisfy USAID guidelines properly.

9. Summary

Write a brief summary, of the highlights of the midterm evaluation covering: composition of the evaluation team; time spent; total costs; field visits; quantitative/qualitative methods; main project accomplishments and measurable outcomes; assessment of applicability and quality of child survival programming; relevance of lessons learned to other child survival and community development programs; key recommendations; planned or actual feedback of evaluation results; author(s) of the midterm evaluation report.

The Evaluation Team:

Rudolf Maier, Team Leader, Andrews University
Dr. Gerard Latchman, ADRA International
Lit. Nelson Tabares, ADRA CS Honduras
Dr. (Mrs.) Aura Delia Ordonez de Castillo, ADRA CS Honduras

Time Table:

May 29- June 6, 1994

Total Cost:

$5,500 (plus local personnel expenses)

Field Visits:

- Interview CHVs, CESAMO directors and social workers--May 30, 31, June 1
- Visit family gardens and income generating projects in San Francisco Colony--May 31, and Flor de1 Campo--June 1;
- Visit UROC units--May 31, June 1.

Evaluation Method:

Qualitative method; verifying data; interviewing people.

Main Project Accomplishments and Measurable Outcomes:

- Training--
  - 14 supervisors trained (6 selected for ADRA project)
  - 136 CHVs trained
  - 1,622 mothers educated
  - 2 doctors and 1 nurse from CESAMO trained
- Breastfeeding--
  - 36% of goal reached
- Weaning--
  - No KAP data available (317 mothers received education)
- Growth Monitoring--
  - 31.4% of goal reached

- Vitamin A--
  Goal reached and exceeded (93%)
- Imrnunization--
  Goal reached and exceeded (93%)
- Antenatal Care--
  Goal reached and exceeded (100%)
- Birth Spacing--
  No KAP data available
- ORT--
  Goal reached and exceeded (98.2%)
- ALRI--
  No Data available
- Home gardening--
  1 1.7% (3 5 families)

Assessment of Applicability and Quality of Child Survival **Programming:**

- Project is making consistent progress.
- Training and supervision of CHVs is integrated into community health structure.
- Good coordination and cooperation with CESAMOs and other NGOs

Relevance of Lessons Learned to Other CS and Community Development Programs:

- Close coordination with existing MOH structures essential.
- SEDs attractive to CHVs and key to sustainability.
- Early technical assistance in launching CS activities essential for progress.
- Sharing of experience from CS Nicaragua valuable to CS Honduras.

Key Recommendations:

- Establish RAP tools to determine effectiveness of training
- Maintain level of technical skills of coordinators
- Monitor and prepare for evaluation of effectiveness of SEDs
- Make attempts to tram community based CHVs supervisors
- Sensitize more mothers on the importance of growth monitoring
- Try to sensitize and involve more men in CS concerns

Planned or Actual Feedback of Evaluation Results:

- Prepare action plan and revised budget for approval by ADRA International by July 15.
- Prepare response and plans how to implement evaluation recommendations by October 15.

Author of Mid-term Report:

Rudolf Maier
(with the assistance of other members of evaluation team).